# WORKERS COMPENSATION COMMISSION

## STATEMENT OF REASONS FOR DECISION OF THE APPEAL PANEL IN RELATION TO A MEDICAL DISPUTE

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| **Matter Number:** | **M1-2225/19** |
| **Appellant:** | **Ivanka Simic** |
| **Respondent:** | **The Croatian Club Ltd** |
| **Date of Decision:** | **16 December 2019** |
| **Citation:** | **[2019] NSWWCCMA 186** |

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| **Appeal Panel:** | |
| **Senior Arbitrator:** | **Josephine Bamber** |
| **Approved Medical Specialist:** | **Dr Brian Noll** |
| **Approved Medical Specialist:** | **Dr Drew Dixon** |

### BACKGROUND TO THE APPLICATION TO APPEAL

1. On 29 August 2019, the appellant lodged an Application to Appeal Against the Decision of Approved Medical Specialist. The medical dispute was assessed by Dr Jonathan Negus, an Approved Medical Specialist (AMS), who issued a Medical Assessment Certificate (MAC) on 2 August 2019.

2. In Part 3 of her Application to Appeal the appellant relies on the following grounds of appeal under s 327(3) of the *Workplace Injury Management and Workers Compensation Act 1998* (1998 Act):

    - The assessment was made on the basis of incorrect criteria
    - the MAC contains a demonstrable error

3. At 4.5 of her Application for Appeal the appellant states she does not seek to rely on additional evidence which was not before the AMS.

4. The Registrar is satisfied that, on the face of the application, at least one ground of appeal has been made out.

5. The Appeal Panel has conducted a review of the original medical assessment but limited to the ground(s) of appeal on which the appeal is made.

6. The *Workers compensation medical dispute assessment guidelines* set out the practice and procedure in relation to the medical appeal process under s 328 of the 1998 Act. An Appeal Panel determines its own procedures in accordance with the *Workers compensation medical dispute assessment guidelines*.

7. The assessment of permanent impairment is conducted in accordance with the *NSW Workers Compensation Guidelines for the Evaluation of Permanent Impairment, 4th* ed 1 April 2016 (the Guidelines) and the *American Medical Association Guides to the Evaluation of Permanent Impairment,* 5th ed (AMA 5).

## RELEVANT FACTUAL BACKGROUND

8. The appellant worked as a waitress for the respondent casually since about 2001. On 31 January 2015, she stumbled over a loose mat near the bar of the respondent's premises. She sustained injuries to her lumbar spine/sacroiliac and to her right upper extremity.

9. The appellant underwent a fusion procedure involving the sacroiliac in July 2016 by Dr Rosenberg and in October 2017 she had a right shoulder reconstruction performed by Dr Popoff.

10. The appellant was assessed for permanent impairment by Dr Endrey-Walder as having a combined whole person impairment (WPI) of 17%, comprised of 6% lumbar spine, 10% right upper extremity and 1% scarring.

## PRELIMINARY REVIEW

11. Prior to conducting the preliminary review, a member of the Panel, Senior Arbitrator Bamber, identified from the Certificate of Determination-Consent Orders dated 5 May 2017 in matter 1565/17, which appears at page 170 of the Application to Resolve a Dispute, that she was the Arbitrator involved in that matter. Senior Arbitrator Bamber advised the Commission of this fact. On 4 November 2019 the Commission's Principal Lawyer, Mr McAdam, sent an email to the legal representatives of both parties enquiring if they objected to Senior Arbitrator Bamber remaining on the Panel. On the same day both parties advised the Commission by email that they had no objection. Accordingly, the Panel remained constituted with Senior Arbitrator Bamber as a member of the Panel.

12. The Appeal Panel conducted a preliminary review of the original medical assessment in the absence of the parties and in accordance with the *Workers compensation medical dispute assessment guidelines.*

13. As a result of that preliminary review, the Appeal Panel identified that there was error in the MAC. However, the Panel did not consider that re-examination by a member of the Panel who is an AMS is required because the main grounds of appeal relate to the deduction made by the AMS under section 323 of the 1998 Act, rather than the AMS's examination of the worker.

14. The reasons for the finding of error are set out below.

## EVIDENCE

### Documentary evidence

15. The Appeal Panel has before it all the documents that were sent to the AMS for the original medical assessment and has taken them into account in making this determination.

### Medical Assessment Certificate

16. In the Amended Referral the AMS was asked to assess permanent impairment of the "right upper extremity, lumbar spine and consequential scarring-TEMPSKI" based upon the Certificate of Determination-Consent Orders issued by an Arbitrator on 6 June 2019.

17. It is noted by the Panel that the lump sum claim made at Part 5.6 of the Application to Resolve a Dispute (ARD) was for these body parts, notwithstanding at Part 4 of the ARD the injury was described as "Lower back, sacroiliac joint and right shoulder".

18. The parts of the medical certificate given by the AMS that are relevant to the appeal are set out, where relevant, in the body of this decision.

## SUBMISSIONS

19. Both parties made written submissions. The appeal relates to the AMS's deduction under s 323 of the 1998 Act in relation to the lumbar spine and the right upper extremity, and to the assessment of scarring. The parties' submissions are considered further below.

## FINDINGS AND REASONS

20. The procedures on appeal are contained in s 328 of the 1998 Act. The appeal is to be by way of review of the original medical assessment, but the review is limited to the grounds of appeal on which the appeal is made.

21. In *Campbelltown City Council v Vegan* [2006] NSWCA 284 the Court of Appeal held that the Appeal Panel is obliged to give reasons. Where there are disputes of fact it may be necessary to refer to evidence or other material on which findings are based, but the extent to which this is necessary will vary from case to case. Where more than one conclusion is open, it will be necessary to explain why one conclusion is preferred. On the other hand, the reasons need not be extensive or provide a detailed explanation of the criteria applied by the medical professionals in reaching a professional judgement.

### Lumbar spine

22. The Panel notes there has been no appeal as to the assessment made by the AMS placing the worker in DRE II, nor in relation to the assessment of activities of daily living (ADL) of 2%. The appeal in relation to the lumbar spine solely relates to the deduction under s 323 of the 1998 Act. Furthermore, the Panel notes there has been no challenge to the finding of the AMS "Sacro-iliac joint – There is no rateable impairment in lower limb DBE or lumbar spine for the sacro-iliac joint fusion". Accordingly, the Panel can only deal with the grounds of appeal raised.

23. The appellant submitted that AMS utilised incorrect criteria and was in error in respect to the assessment of the deduction pursuant to s 323 of the 1998 Act for pre-existing condition of the lumbar spine. Reference is made in the appellant's submissions to 1.28 of the Guidelines, as follows:

> "In assessing the degree of permanent impairment resulting from the compensable injury/condition, the assessor is to indicate the degree of impairment due to any previous injury, pre-existing condition or abnormality. This proportion is known as the 'the deductable portion' and should be deducted from the degree of permanent impairment determined by the assessor. For the injury being assessed, the deduction is 1/10th of the assessed impairment, unless that is at odds with the available evidence".

24. The appellant argues that it is apparent that the AMS used incorrect criteria because in the MAC at paragraph 8 the AMS answered questions (e) and (f) by "no" and "Not applicable", respectively. These questions relate to whether there is any proportion of the WPI due to a previous injury, pre-existing condition or abnormality. It is also submitted that there is an internal contradiction in the MAC as at paragraph 10 the AMS finds objective evidence of pre-existing disease within the lumbar spine, and then proceeds to make a deduction of ½.

25. The appellant submits that the AMS has not correctly applied the Guidelines in dealing with the "objective evidence of pre-existing degenerative disease". It is argued that the radiology available to the AMS does disclose some age-related degenerative changes at L4/5, but notes these changes were described in those radiology reports as "mild" (page 4, paragraph 1 of the MAC) and "minimal" (page 4, paragraph 3 of the MAC). It was submitted that a proper deduction should have been nil or at the most 1/10 based on the available evidence and the worker's history and presentation.

26. The appellant further submits:

> "The AMS notes the main reason for the fusion surgery was due to injury to the sacroiliac joint, which required that it be attached more securely to the lumbar spine. This is accepted on the basis of the reports of Dr Rosenberg and Dr Endrey-Walder. The need for this procedure was clearly not due to age related degenerative changes. Particularly when the early post injury radiology of the lumbar spine found these changes to be mild and not apparently restricting the Worker from performing her physical work."

27. The respondent submits that there appears to be a typographical error in points 8(e) and (f) of the MAC wherein the AMS answers no to the questions about pre-existing conditions and abnormalities. This seems likely given the AMS's subsequent findings. The respondent suggests the AMS should be given the opportunity to correct this via an application for reconsideration. The respondent submits that the AMS has explained why the available evidence is at odds with a one-tenth deduction. However, for the reasons discussed below the Panel does not accept this submission.

28. The AMS found at point 11 of his MAC that the worker suffers from the pre-existing condition or abnormality of lumbar spine spondylosis. He explains that,

> "The injury of 31 January 2015 exacerbated the degeneration in the lumbar spine. However, the sacroiliac joint appeared to be the major source of pain from the injury on 31 January 2015. The lumbar spine became more symptomatic after the motor vehicle accident of 2016."

29. The AMS then states his opinion is that the deductible proportion for the lumbar spine should be 1/2 because:

> "(i) The majority of the symptoms from the injury of 31 January 2015 were not from the lumbar spine but from the sacro-iliac joint which underwent fusion surgery. The lumbar spine symptoms became more pronounced after the motor vehicle accident of 2016."

30. The Panel finds this explanation discloses error. The AMS is assessing permanent impairment of the lumbar spine. He offers the above as reasons why he has decided to make a deduction of one-half for a pre-existing condition or abnormality, but none of the factors he identifies are pre-existing. The later motor vehicle accident is certainly not. The fact that he finds the majority of the symptoms are from the sacro-iliac joint is not to the point as he specifically only assesses the worker in relation to the lumbar spine. The referral was only in relation to the lumbar spine, no doubt because Dr Endrey-Walder only assessed the lumbar spine using Chapter 15.4 of AMA 5 for the lumbar spine. Dr Endrey-Walder did not attempt an assessment of the lower extremity or pelvis to ascertain if the sacro-iliac surgery was rateable.

31. The reasons given by the AMS for the s 323 are confusing and the Panel finds the AMS's reasons are inadequate and amounting to a demonstrable error and disclose that the AMS has applied incorrect criteria. The AMS has not in fact explained why there should be a deduction of one-half. Furthermore, apart from the probable typographical errors in point 8 of his MAC, the AMS when giving his diagnosis in point 7 states "the majority of her lumbar spine symptoms are left-sided leg pain from the L4/5 level." This seems inconsistent with his findings expressed at point 11, discussed above.

32. Having found error, it is necessary for the Panel to assess the appropriate deduction.

33. No assistance can be gleaned from Dr Endrey-Walder's reports because he does not discuss the application of s 323.

34. Dr Rosenberg, in report dated 28 October 2015 to the insurer, stated that the MR scan showed some age-related wear and tear and desiccation of the lower lumbar discs. In report dated 27 January 2017 to Dr Stojanovska-Petrovska, Dr Rosenberg stated,

> "There is no doubt that she does have some pre-existing lumbar spinal issues. There is some degeneration of the lower 2 lumbar discs and this would have been stirred up by the fall."

35. The AMS's summary of the radiological reports reveals the following:

> "February 2015 CT lumbar spine. No acute bony injury. No significant disc space abnormality to account for the patient's symptoms demonstrated. Minor circumferential disc bulge present at L4/5 and L5/S1 without causing foraminal stenosis. Mild narrowing of the right L4/5 neural foramina due to osteophyte encroachment.
>
> MR lumbar spine 20/03/2015 - mild spondylotic change in the lower lumbar spine. Small left far lateral disc protrusion at L3/4 with mild impingement of the left L3 nerve root. No cause for the patient's right leg pain identified.
>
> X-ray lumbar spine 02/04/2015 - reported as several millimetres of retrolisthesis at L4/5. Vertical alignment does not change between flexion/extension. My take is there is some mild degenerative change seen but disc height preserved. There are changes at the right SI joint."

36. It is evident from these reports, as well as those of Dr Rosenberg, that the worker did have pre-existing lumbar abnormalities, albeit not symptomatic. However, the Panel is of the opinion that such degenerative changes have contributed to her permanent impairment and it is appropriate to make a deduction under s 323 of the 1998 Act. The Panel finds that the amount of that deduction is too difficult to determine and in accordance with s 323(2) the deduction should be one-tenth.

37. Accordingly, the MAC is revoked, and a fresh certificate is issued with the assessment of the lumbar spine being DRE II 5% add 2% for interference with ADL, making a total of 7% and deducting one-tenth leaves a total of 6% WPI.

**Right upper extremity**

38. The parts of the MAC dealing with the right shoulder are reproduced below. The AMS considered the radiology as follows:

> "X-ray and ultrasound – 29/04/2015 - right shoulder demonstrating good glenohumeral joint space – no significant arthrosis, otherwise normal. Report for the ultrasound is all tendons intact, no rotator cuff tear or tendinosis, mild subacromial subdeltoid bursal thickening, suggesting minor bursitis, limited shoulder abduction to 40° secondary to pain and bursal bunching is identified. Long head of biceps intact. The x-ray report is normal.
>
> MRI arthrogram right shoulder 07/08/2015 - report is of 2 tiny tears at the supraspinatus insertion, measuring 1 – 2mm with mild supraspinatus tendinosis. The remaining cuff intact. Mild subacromial bursitis. Images sighted and I agree.
>
> 01/03/2018 - MRI right shoulder with gadolinium - reported as supraspinatus repair intact. No evidence of re-tear. Mild tendinosis. Subacromial bursitis. Non-visualisation of approximal LHB, suggestive of rupture. Capsulitis. No osteoarthritis. Images sighted and I agree."

39. The AMS considered other medical reports in relation to the right shoulder as follows:

> "Dr Popoff felt in his letter of 15 May 2015 that the right shoulder diagnosis was impingement as well as a recurrence of carpal tunnel syndrome. He injected her subacromial space. When he reviewed her MRI on 16 September 2015, he found a small tear in the anterior supraspinatous evident degenerative long head of biceps tendon. This is when he offered her the right shoulder arthroscopy with beast biceps tenodesis subacromial decompression and rotator cuff repair."

40. In point 11 of his MAC the AMS found that the worker suffered from pre-existing condition or abnormality in the right shoulder and explained at sub-paragraph b(ii) that "there was evidence of age-related pre-existing degenerative change in the imaging with evidence of an acute injury." In sub-paragraph c(ii) the AMS found the extent of the deduction for the shoulder under s 323 was difficult or costly to determined so he applied the deduction of one-tenth.

41. In point 10 of his MAC the AMS assessed that the right shoulder had impairment due to lack of range of motion, citing Figures 16-40, 16-43 and 16-46 of AMA 5 to come to an upper extremity impairment (UEI) of 11%, which equates to 7% WPI. He then deducted one-tenth for s 323 to arrive at assessment of 6% WPI.

42. The appellant's submission in relation to the assessment of the right upper extremity (shoulder) is that the AMS has committed a similar demonstrable error or applied incorrect criteria in respect to the deduction under s 323 of the 1998 Act as he did in relation to the lumbar spine. It is submitted that a correct construction of s 323 would result in a finding,

> "that there was no basis for an automatic deduction of 1/10$^{th}$ in respect of the Worker's right shoulder purely based on the post-accident radiology and a post-surgical examination, with no connection being made as to any prior treatment, restriction, pathology, or other evidence that there was any impact on her before the subject work injury."

43. The appellant was critical of the AMS because the AMS stated that the "shoulder showed evidence of age related pre-existing degenerative change in the imaging with evidence of an acute injury". It was submitted that there is no description of what was in the imaging to suggest a history of pathology prior to the "acute injury", and that was nothing disclosed on the MR Arthrogram of 7 August 2015. It was also submitted that in paragraph 11 of the MAC with respect to "pre-existing condition", the AMS just stated "right shoulder".

44. At 5.11 of the appellant's submissions it is stated that the AMS accepted the unchallenged history of the worker that she did not experience right shoulder symptoms impacting her capacity to work as a function waitress prior to the fall in January 2015.

45. It is submitted at 5.13,

> "The AMS refers to radiology in respect to the right shoulder also referred to by Dr Endrey-Walder in his main report of 30 July 2018. The AMS deducts 10% apparently based on this material. Dr Endrey-Walder reviewing the same radiology states 'This lady had no pathology, no symptoms whatsoever at her right shoulder prior to the fall at the Club' (Page 8, paragraph 4). Dr Endrey-Walder having carefully considered all of the same radiology mentioned in the MAC. The need for shoulder surgery was solely due to the acute injury suffered by the Worker and there is no suggestion of any relevant underlying pathology, disclosed on radiology, in this regard."

46. The respondent's submissions at point 8(g) assert that the "Appellant has failed to provide details of incorrect details relied on by the AMS, but rather seeks to rely on the fact that a different conclusion was reached by their own IME." It was also submitted at point 12 that the AMS using radiological evidence to make a one-tenth deduction in relation to the right shoulder was in accordance with Part 2, Clause 1.28 of the Guidelines.

47. Dr Endrey-Walder's assessment differed to the AMS in two respects. Firstly, he assessed 16% UEI, which is equivalent to 10% WPI. Secondly, he did not make a deduction under s 323. However, Dr Endrey-Walder did not consider s 323 at all. Furthermore, even though Dr Endrey-Walder stated that the worker had no pathology or symptoms before the fall, he does not comment on the findings of Dr Popoff, the treating shoulder surgeon which reveal the presence of degenerative change.

48. The AMS did consider Dr Popoff's opinion and refers in his MAC to Dr Popoff's finding of "degenerative long head of biceps tendon", as quoted above. However, the Panel notes that Dr Popoff, in the report to Dr Sebez dated 16 September 2015 when discussing the MRI, says "there is also a *very degenerate* long head of biceps tendon." (emphasis added) The operation report of Dr Popoff dated 10 October 2017 referred to "There was a subacromial spur which was excised exposing a degenerate distal clavicle. This was excised through an accessory anterior portal."

49. The Panel also notes in the ARD is the Medical Assessment Certificate of Dr Burrow, in his capacity of an AMS in matter 1565/17, when dealing with the question of whether the proposed surgery to the right shoulder was reasonably necessary. In his history, Dr Burrow acknowledges that the worker had no prior right shoulder symptoms before the fall. In his summary of injuries and diagnoses, Dr Burrow stated

> "Dr Popoff, a respected orthopaedic shoulder surgeon, has confirmed impingement and cuff pain as well as biceps pain and has recommended shoulder examination, acromioplasty or decompression to deal with the impingement, cuff inspection if there is a significant cuff tear, repair and also biceps inspection and/or tenodesis if it is significantly degenerate."

50. The operation report dated 10 October 2017 reveals that the operation performed by Dr Popoff was a "right shoulder arthroscopic rotator cuff repair, subacromial decompression, biceps tenotomy & excision of distal clavicle."

51. Dr Burrow also found,

> "It is my opinion that the probable explanation is that she had a degree of bursitis and perhaps cuff tendinitis as many people of her age do and that it became aggravated with the fall…It is clear in my mind, however, that the work fall resulted in an injury to the right shoulder and that injury involves persistent impingement, aggravation of pre-existing cuff tendinosis and/or biceps pathology."

52. Taking into account all of the evidence that was before the AMS, the Panel finds that the appellant has not made out the ground of appeal that the s 323 deduction made by the AMS was in error. The Panel finds there was ample evidence before the AMS for him to conclude that "there was evidence of age-related pre-existing degenerative change in the imaging" and that a deduction of one-tenth was appropriate because it was too difficult to otherwise determine in accordance with s 323(2) of the 1998 Act.

53. The Panel considers that the fact that the AMS did not refer to the pre-existing condition or abnormality in point 8 of his MAC, while an error, is not such that infects the AMS's findings regarding the deduction that should be made under s 323. Should the Panel be incorrect in such a conclusion, the Panel, if required to assess the deduction, finds that a one-tenth deduction under s 323 of the 1998 Act is appropriate based on the evidence discussed above. The Panel finds the abovementioned evidence supports the existence of a pre-existing condition or abnormality which has contributed to the permanent impairment suffered by the worker and as this is too difficult to determine, a one-tenth deduction should be made.

54. The Panel finds there has been no application of incorrect criteria by the AMS when assessing the right upper extremity.

**Scarring**

55. The AMS in his MAC deals with the scarring under point 10. He states:

> "Skin scarring – Table 14.1 TEMSKI
> All scars are well healed with no negative features and Mrs Simic is not conscious of them.
> - TEMSKI -0%"

56. The appellant's submissions in relation to the assessment of scarring do not actually point to the application of incorrect criteria or any demonstrable errors; except it is submitted that the worker "does not seem to have been questioned by the AMS about this nor are any reasons provided for the 0% in the MAC despite a 5cm surgical scar noted by Dr Endrey-Walder in his report." It was noted in the submissions that the scarring was "significant".

57. In response to the appellant's submission that no reasons were provided for the 0% impairment in relation to TEMSKI, the respondent refers to the reasons in the MAC, to which the Panel has referred above.

58. The Panel finds that, while the AMS has expressed himself economically, it is evident that he did discuss the scarring with the worker because he says Mrs Simic is not conscious of the scarring. The Panel also notes that in 14.6 of the Guidelines a scar may be present and rated as 0% WPI and that uncomplicated scars for standard surgical procedures do not, of themselves, rate an impairment. While the surgery performed on the worker may not be "standard" in the sense of being performed often, the Panel notes that it has not been submitted that any of the features in Table 14.1 of the Guidelines are present such as to place the worker in 1% WPI as opposed to 0% WPI. The AMS found the scarring to be well healed and no negative features. The Panel finds the reference to "no negative features" supports placement in 0% WPI.

59. The worker has supplied two statements which are in her ARD and she does not refer to being conscious of her scarring or to any changes such to place her in 1% WPI, such as trophic changes or colour contrast; indeed, she does not refer to the scarring at all.

60. Dr Endrey-Walder in the reports of 15 February and 30 July 2018 describes the scar as being 5cm in length, horizontal in the right buttock. He gives no reasons at all for assessing 1% WPI. Dr Miniter on page 3 of his report dated 9 November 2018 describes the scar as well healed.

61. The Panel finds there has been no demonstrable error or application of incorrect criteria by the AMS when assessing the scarring.

**Summary**

62. For these reasons given above regarding the assessment of the lumbar spine, the Appeal Panel has determined that the MAC issued on 2 August 2019 should be revoked, and a new MAC should be issued. The new certificate is attached to this statement of reasons.

I CERTIFY THAT THIS IS A TRUE AND ACCURATE RECORD OF THE REASONS FOR DECISION OF THE APPEAL PANEL CONSTITUTED PURSUANT TO SECTION 328 OF THE *WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998*.

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Lucy Golic
Dispute Services Officer
**As delegate of the Registrar**

# WORKERS COMPENSATION COMMISSION

## APPEAL PANEL
## MEDICAL ASSESSMENT CERTIFICATE

**Injuries received after 1 January 2002**

**Matter Number:** **M1-2225/19**
**Applicant:** **Ivanka Simic**
**Respondent:** **The Croatian Club Ltd**

This Certificate is issued pursuant to s 328(5) of the *Workplace Injury Management and Workers Compensation Act* 1998.

The Appeal Panel revokes the Medical Assessment Certificate of Dr Negus and issues this new Medical Assessment Certificate as to the matters set out in the Table below:

**Table - Whole Person Impairment (WPI)**

| **Body Part or system** | **Date of Injury** | **Chapter, page and paragraph number in WorkCover Guides** | **Chapter, page, paragraph, figure and table numbers in AMA5 Guides** | **% WPI** | **% WPI deductions pursuant to S323 for pre-existing injury, condition or abnormality** | **Sub-total/s % WPI (after any deductions in column 6)** |
|---|---|---|---|---|---|---|
| Right upper extremity | 31/01/15 | | Figures 16-40, 16-43, 16-46 | 7% | 1/10 | 6% |
| Lumbar spine | 31/01/15 | Chapter 4 Paragraphs 4.34, 4.35 | Chapter 15 Page 384 Table 15-3 | 7% | 1/10 | 6% |
| Scarring | 31/01/15 | Chapter 14 Paragraphs 14.6, and Table 14.1 | | 0% | 0 | 0% |
| **Total % WPI (the Combined Table values of all sub-totals)** | | | | | **12%** | |

The above assessment is made in accordance with the Guidelines for the Evaluation of Permanent Impairment for injuries received after 1 January 2002.

**Josephine Bamber**
Senior Arbitrator

**Dr Brian Noll**
Approved Medical Specialist

**Dr Drew Dixon**
Approved Medical Specialist

16 December 2019

I CERTIFY THAT THIS IS A TRUE AND ACCURATE RECORD OF THE MEDICAL ASSESSMENT CERTIFICATE OF THE APPEAL PANEL CONSTITUTED PURSUANT TO SECTION 328 OF THE *WORKPLACE INJURY MANAGEMENT AND WORKERS COMPENSATION ACT 1998*.

L Golic

Lucy Golic
Dispute Services Officer
**As delegate of the Registrar**